

**MARKET CONDUCT EXAMINATION REPORT**

**of**

**THE CUNA MUTUAL INSURANCE SOCIETY**

**of**

**MADISON, WISCONSIN**

**As of**

**December 31, 2003**

**By**

**VERMONT DEPARTMENT OF BANKING,  
INSURANCE, SECURITIES AND HEALTH CARE  
ADMINISTRATION**



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April 11, 2006

The Honorable John Crowley  
Commissioner  
Vermont Department of Banking, Insurance,  
Securities and Health Care Administration  
89 Main Street, Drawer 20  
Montpelier, Vermont 05620

Dear Commissioner Crowley:

Pursuant to your instructions and in compliance with the provisions of 8 V.S.A. § 3565 et seq. and procedures promulgated by the National Association of Insurance Commissioners, an examination of the market conduct activities has been conducted of:

The CUNA Mutual Insurance Society, NAIC # 62626

Mail Address:  
Post Office Box 391  
Madison, Wisconsin 53701

Statutory Home Office:  
5910 Mineral Point Road  
Madison, Wisconsin 53705

Main Administrative Office:  
5910 Mineral Point Road  
Madison, Wisconsin 53705

The report thereon, as of December 31, 2003, is respectfully submitted.

## **FOREWORD**

This target market conduct examination report is written generally by exception and references to additional practices, procedures and files subject to review during the examination were omitted from the report if no improprieties were observed.

The CUNA Mutual Insurance Society is referred to throughout this report as the “Company” or CUNA, unless specifically mentioned by name. The Vermont Department of Banking, Insurance, Securities and Health Care Administration is referred to as the “Department” or the “Vermont Department”.

The Company’s responses, with respect to the findings of this examination, will be made available upon written request to the Vermont Department.

The examiners wish to acknowledge the exceptional cooperation of the Company’s Corporate Compliance Manager, Kathy Graham in facilitating the examination process.

## **SCOPE OF EXAMINATION**

### **EXAMINATION AUTHORITY**

The examination of the CUNA Mutual Insurance Society was conducted pursuant to applicable Vermont statutes and regulations.

### **TIME FRAME**

The examination generally covers the period from January 1, 2001 through December 31, 2003.

### **SAMPLING METHODOLOGY**

The examiners used random sampling techniques, utilizing ACL software.

### **EXAMINATION SITUS**

The Company's statutory home office is located at 5910 Mineral Point Road, Madison, Wisconsin; however, this examination was conducted entirely off-site. Information, documents and other materials were provided directly to the examiners in hard copy and/or on computer diskettes and by electronic mail.

### **MATTERS EXAMINED**

- Supervision of credit lenders
- Use of properly filed rates and forms
- Accuracy of premium rates and refunds
- Claims administration
- Marketing and sales

## **PREVIOUS EXAMINATIONS**

### **PRIOR REPORT SUMMARY AND CONCLUSIONS**

The Vermont Department did not conduct an examination of the Company during the last five years.

## EXECUTIVE SUMMARY

This section of the report is merely a summary of those findings of the examiners that they believe to be the most significant and, therefore, is not intended to be all inclusive of the total findings discussed in this report. It should also be noted that Company representatives did not agree with all of the opinions and/or conclusions of the examiners expressed in the report. It was not practical to include complete references to all areas of Company disagreement in this summary. Thus, it would be necessary for one to read the report in its entirety in order to gain complete knowledge of the Company's position regarding each individual opinion or conclusion with which they disagree.

### **Production of Records**

#### **(A) Lengthy Delays in Receiving Records**

The examiners encountered unreasonably long delays in receiving records required to perform the examination causing the examination to last far longer than it otherwise would have. For example, when the examiners initially requested listings of certificates from which to choose samples of files for testing, it took eight (8) months just to receive the listing (not the files) from one credit union. Once the examiners selected the sample files from the listings, further delays were encountered in receiving the files. Again, it took eight (8) months to receive the requested sample files from another credit union once the sample files were selected by the examiners from the listing. There were numerous other similar delays in receiving documents and records that were requested for review. Further, when the initial samples sizes were being determined the Company erroneously informed the examiners that one credit union wrote 72,733 certificates during the examination period when, in fact, they had only written less than 150 certificates. This error was reported to the examiners long after the samples had been selected causing the selected samples sizes for all of the credit unions to be incorrect. Incidentally, it took eight (8) follow-up letters from the examiners before the initial listing of certificates for this credit union was received in the first place and then this erroneous information was reported far into the examination when it was too late to make necessary corrections.

There were many other delays in receiving documents and records that were requested for review. Ten (10) follow-up requests for a status report of the outstanding items were sent to the Company over the period from 11-11-04 to 5-17-05.

A major factor contributing to the problems in receiving documents and records from the Company was the fact that the individual credit unions rather than the Company keep most of the records and some were unable to produce them when requested by the Company as discussed in this report.

## **(B) Company's Failure to Produce Documents and Other Irregularities**

The Company failed to produce numerous documents requested as part of the sample files and in at least two (2) instances 100% of the sample files were incomplete. Such failures constitute violations of Vermont's Record Retention Regulation 99-1.

Other failures to produce documents include the following:

1. Failure to produce a requested listing of rejected (declined) and amended certificates in violation of Vermont Regulation 99-1 § 6.
2. Failure to provide evidence verifying payment of claims.
3. Numerous miscellaneous inaccuracies in reporting population sizes for various categories of claims. An example is a case where the Company certified that the total number of denied Loan Protection life claims was sixty-six (66). It wasn't until over one year from the date the examination began that the Company furnished a corrected report showing the number to be thirty-eight (38).
4. The Company could not produce an accurate number for the credit life certificates that were issued to Vermont insureds during the examination period. They use figures estimated by a ratio method for reporting in their annual financial statements.

The Company's failure to produce its records for examination as detailed in the report constitutes violations of Vermont Regulations 99-1 § 4 A. (1) and (2), 99-1 § 6, 99-1 § 7 A. (1) and § 7 B.

The Company agreed to rectify this situation and the examiners made recommendations in the report including a recommendation that the Vermont Department conduct a follow up examination commencing within eighteen months following the close of this examination in order to ensure that the Company's procedures and practices are in full compliance with Vermont Regulation 99-1.

## **Claims Procedures and Processing**

### **(A) Failure to Pay Interest on Credit Life Claims**

The Company does not pay the statutorily required interest on death claims in accordance with 8 V.S.A. 3665 (c ), nor does it pay the penalty rate (12%) for those claims paid beyond thirty (30) days of the receipt of proofs of loss in violation of 8 V.S.A. § 3665 (d).

The Company is not in agreement with the examiners and contends that 8 V.S.A. 3665 (c ) does not apply to credit life insurance claims. A detailed discussion of the Company's position is contained in the text of this report.

The examiners have recommended that the Company go back as far as the Vermont Department deems appropriate and pay with interest those amounts due to the beneficiaries of the affected insureds. The examiners further recommended that the Company implement procedures by which full compliance with 8 V.S.A. § 3665 (c ) and (d) is assured.

### **(B) Paid Life Claims**

The Company did not audit the credit union policyholders to ensure that they pay claim amounts in excess of the unpaid loan balances to the insured's beneficiary or estate. Refer to sections II (B) and V of this report for a detailed discussion of the Company's failure to conduct periodic reviews of creditors with regard to their credit operations, in violation of Regulation 84-1 § 11.

### **(C) Denied Disability Claims**

The Company had denied a credit disability claim on the grounds that it wasn't filed until more than one year from the time it should have been filed. The examiners observed that a claim notice had been received around 4-4-03 for a loss date of 7-26-01, however, the file also contained a reference to a notice completed on 9-1-01 for the same claim. After the examiners requested an explanation, the Company stated that: *If this claim was received in our office today, we would process the claim for benefits according to the terms of the certificate, in the absence of the timely filing requirement. Therefore, we have calculated (name) disability claim for benefits and determined a benefit payment of \$7,582.38.* (Emphasis added)

Other miscellaneous claim handling violations are discussed in detail under the same section of this report.

#### **(D) Company's Practice of Determining Effective Date of Coverage**

The examiners observed that the Company's practice of determining the effective date of coverage is not in accordance with Regulation 84-1 § 7 (2) (a) for reasons discussed in detail in the report. This significantly impacts the denial of disability claims on the grounds of pre-existing conditions. The Company disagrees with the examiners' criticism stating that forms consistent with the Company's practices were approved by the Department. The examiners are recommending that the Department reconsider their approval of the Company's form.

#### **(E) Loan Protection**

The Company does not pay the statutorily required interest on claims under its Loan Protection Program. This is a non-contributory group credit program. Since the covered members do not contribute directly toward the premium, the Company contends that their beneficiaries are not entitled to the interest. The examiners do not agree with the Company's position. A detailed discussion of this issue can be found under the section of this report entitled **Claims Procedures and Processing (E) Loan Protection**.

#### **Rates and Related Issues**

Various violations of regulations governing rates and/or related irregularities discussed under this section include the following:

1. Differences between the coverages elected by the covered member and the coverages for which they were charged.
2. Overcharges in premiums.
3. Mixing experience for 14 day non-retro with that of 30 day non-retro in determining the deviated rate for 14 day non-retro for one credit union in violation of Regulation 84-1 § 10 (3) (c).

#### **Form Filings**

Various violations of regulations and/or irregularities discussed under this section include:

1. Certificates of insurance which do not include all of the required information in violation of 8 V.S.A. § 4107 (b) and Vermont Regulation 84-1 § 3 (3) (b).
2. Use of forms that were not approved, in violation of 8 V.S.A. § 4108 (a).

#### **Supervision of Credit Insurance Operations**

The Company admittedly failed to perform any periodic reviews of its Vermont creditors (credit unions) in violation of Vermont Regulation 84-1 § 11.

As a result of this examination the Company initiated corrective action by implementing a review program effective December 2005, which is detailed in Sections II (B) and V of this report. The examiners have recommend that the Department conduct a follow up review of its newly implemented program in order to assure that the self assessment practice employed by the Company is effective in assuring compliance with the insurance laws of Vermont and the regulation promulgated by the Commissioner.

**Producer Licensing**

Persons engaged in the solicitation (selling) of insurance through the Company have not been licensed in accordance with 8 V.S.A. § 4793 (a) and § 4813b and appointed as required by 8 V.S.A. § 4813l. The examiners have recommended that these persons become duly licensed in accordance with Vermont's licensing laws.

## **COMPANY PROFILE**

### **HISTORY**

CUNA Mutual Insurance Society is a mutual life insurance company incorporated under the laws of Wisconsin on May 20, 1935 by persons associated with the credit union movement.

The Company, which is licensed in all of the states, the District of Columbia, Puerto Rico and Canada, is the lead company in the CUNA Mutual Group holding company system. The CUNA Mutual Group maintains a dominant position as the provider of life and health products to members and employees of credit unions.

The credit unions are group master contract policyholders and, as such, have voting rights by virtue of membership in the mutual company. Thus, the Company is owned and controlled by the credit unions and their members.

Two of the primary products written by the Company are credit life and credit disability insurance covering the unpaid balances of loans made by the credit unions to their members. The benefits are payable directly to the credit unions to the extent of the members' indebtednesses. These policies were the focus of this market conduct examination.

### **STATUTORY HOME OFFICE**

5910 Mineral Point Road  
Madison, Wisconsin 53705

### **MAIN ADMINISTRATIVE OFFICE**

5910 Mineral Point Road  
Madison, Wisconsin 53705

## VERMONT REPORTED PREMIUMS

Direct written premiums in Vermont for the years indicated are as follows:

	<b>2001</b>	<b>2002</b>	<b>2003</b>
<b>Credit Life (Group and Individual)</b>	1,078,328	1,053,373	1,003,890
<b>Other Life</b>	821,281	868,209	832,010
<b>Annuities (Group and Individual)</b>	2,992,672	1,349,097	1,504,215
<b>Credit Disability (Group and Individual)</b>	1,877,932	1,886,313	1,788,364
<b>Other Disability (A &amp; H)</b>	572,939	648,819	820,845
<b>Totals</b>	<b>7,343,152</b>	<b>5,805,811</b>	<b>5,949,324</b>

## **(I) PRODUCTION OF RECORDS**

Regulation 99-1 establishes rules for the preservation and retention of insurer records and the requirements for production of such records for examination. The Company does not maintain its records in accordance with Vermont's Regulations 99-1 § 4 A. (1) and (2), 99-1 § 6, 99-1 § 7 A. (1) and § 7 B.

This section of the report discusses in detail the Company's failure to make records subject to examination readily available and the resulting major hindrance to the examination process.

### **(A) LENGTHY DELAYS**

On September 10, 2004, the examiners requested listings containing all certificates that were issued in Vermont during the examination period as part of the "Preliminary Examination Data Request". The requested listings were to be furnished on or before November 1, 2004, the date the examination was scheduled to begin.

The Company responded that the only records of issued certificates which were readily available were those representing single premium products (by far the minority of the total business written in Vermont). More importantly, the Company added that the credit unions (group policyholders) hold the records for all monthly term level rate certificates and that the only record the Company receives is a monthly reporting of premiums and the number of covered loans. It is important to note that the majority of credit life and credit disability insurance CUNA writes in Vermont is monthly term level rate coverage.

In order to select sample files for the review, the examiners were furnished a listing representing a summary of the total number of insured loans (number of certificates issued) for each of the thirty-six (36) credit unions within the listing, for a one month period (in this case for the month ending September 30, 2004). The examiners selected nine (9) credit unions (of the thirty- six (36) listed on the summary) for the review. These nine (9) credit unions appeared from the information to have written the greatest numbers of certificates in Vermont.

Upon receiving the listings of the selected credit unions, the Company sent letters to these nine (9) credit unions requesting records representing all certificates which were issued in Vermont during the examination period. The examiners were to select sample files from this listing.

There were considerable delays in receiving first the listings of issued certificates from the credit unions and secondly the samples once the examiners had received the listings and selected the samples. For example, on October 13, 2004, the examiners provided the Company with the request for the listings of those nine (9) selected credit unions from

which samples would be drawn. The listing for United Community was not received until June 7, 2005, almost eight (8) months later.

Further, one of the nine (9) credit unions selected was St. Peter's Community which appeared to have written the largest numbers of certificates in Vermont. The initial listing indicated that St. Peter's Community wrote a total of 72,733 level rate credit disability certificates, while the next largest population was 3,959 written by Vermont State Employees. As mentioned above, the examiners experienced substantial delays in receiving the listings and with respect to the listing for St. Peter's Community, eight (8) follow up requests were made as to the status of receipt of that listing. It wasn't until March 2005, that the examiners were made aware of an error in reporting the approximate population of the numbers of certificates written by St. Peter's Community. The Company advised that the correct total for the period should have been less than 150. The credit union apparently reported the amount of insured loans, not the count. This incorrect reporting of the credit union's population made it necessary for the examiners to adjust the sample requests in order to attain a more statistically correct number of sample files to be reviewed, thus encountering additional delays in receiving the requested documents.

Additionally, the Company encountered problems in furnishing the samples for the single premium issued life sample for the Ethan Allen Credit Union. The initial request for the sample files was made on November 10, 2004. The examiners did not receive the requested files until July 7, 2005, almost eight (8) months later.

There were numerous other similar delays in receiving documents and records that were requested for the review. Ten (10) follow up requests for a status report of the outstanding items were sent to the Company during the course of the examination. The dates of those follow up requests were: 11-11-04, 11-22-04, 12-01-04, 12-22-04, 12-31-04, 1-26-05, 2-17-05, 3-8-05, 4-05-05 and 5-17-05.

The examiners acknowledge that the Company replaced the examination coordinator effective April 1, 2005, with Ms. Kathy Graham, after which, the requested documents, records, inquiries etc., were furnished in a more timely manner.

## **(B) COMPANY’S FAILURE TO PRODUCE DOCUMENTS**

### **(1) Sample Selection-Incomplete Files**

The examiners randomly selected sample files from the listings representing various populations for review. The following chart displays the numbers of items the Company failed to produce, in violation of Vermont’s Record Retention Regulation 99-1.

<b>Contract Number of Credit Union</b>	<b>Sample Size (Number of Requested Files)</b>	<b>Number of Incomplete or Missing Documents</b>
044-0003-0	50	25 (50% of the sample)
044-0029-5	50	18 (36% of the sample)
044-0048-6	10	5 (50% of the sample)
044-0006-2	10	10 (100% of the sample)
044-0078-7	35 (Issued Life Sample) 35 (Terminated Sample) 22 (Issued Disability Sample) Total sample size 92	38 (41% of the sample)
044-0082-6	5	5 (100% of the sample)
044-0060-6	50	1 (2% of the sample)

### **(2) Failure to Produce Rejected/Amended Listings**

The examiners requested a listing of all certificates which were rejected (declined) and amended during the examination period. The Company failed to produce the requested listings in violation of Regulation 99-1 § 6.

## **(C) CLAIMS RECORDS-IRREGULARITIES**

Regulation 99-1 § 4 A. (3) requires an insurer to maintain its claims records *so as to show clearly the inception, handling and disposition of each claim.* (Emphasis added)

### **(1) Determining Date of Receipt of Claim**

During the course of review of the Company's denied monthly premium credit disability claims, the examiners encountered difficulties in determining the date the Company received the claim notice. The Company utilizes a form entitled "**Initial Claim Report**" which serves as their "acknowledgement of claim" and reflects the actual receipt date. However, during the examination period, the ENOC (Electronic Notice of Claim) was dated one day later than the Initial Claim Report, thus creating confusion as to when the claim was actually received. The Company's explanation as to why claims were dated in such a manner was: *Our previous claims processing system, when mapping the received date of an electronic notice of claim (ENOC), populated the next business day as the actual receipt of the electronic notice.*

The Company advised that an updated claims processing system was implemented as of 8-1-04, and that this procedure is no longer used.

### **(2) Absence of Payment Verification**

The examiners selected a sample of paid credit life claims, which were drawn from listings provided in response to the Preliminary Examination Data Request. Upon submitting the request for the sample claim files, the examiners requested among other items, that the Company also furnish verifying evidence that claim benefits were actually credited (or paid directly to) the insured debtor's account. Note, that the Company does not maintain copies of the credit unions' members' accounts and that this information (actual copies of the members' accounts) would have to have been furnished by the individual credit unions.

The Company's claims systems do however, store information pertaining to payment transactions involving the payments made to the credit unions' accounts. This information was provided for the review, which consisted of computer print outs indicating the amounts paid to the individual credit unions.

During the course of the review of the sample files, the examiners observed that ten (10) sample claim files did not contain the requested verifying evidence (members' account statements or other verifying documents) that the claim benefit was applied to the insured debtor's account or paid directly to the beneficiary.

Upon inquiry as to the missing documents, the Company responded in relevant part:

*The claim processing system used to adjudicate these claims does not store payment transactions in the claim file. Therefore, payment transactions were not produced during file preparation associated with this audit. Screen prints of the payment transactions are attached.*

**Note: Company's comments subsequent to the examination:**

The Company was afforded an opportunity in which to respond to *factual* assertions or errors contained in the draft report prior to submission to the Department. The following objection, with respect to the above section of this report, was received from the Company:

*We would like to reiterate that not providing the payment support information during the initial data call was the result of miscommunication between the examiners and the Company. The data call did not provide specifics as to what documents were to be provided and therefore the payment information was not included. We acted promptly in providing payment support information upon specific request from the examiners. Therefore, we respectfully request that these references be removed from the report, including Appendix I. (Emphasis added)*

The *initial data call*, to which the Company refers, did not contain a request for documents (the sample claim files) conversely; the Preliminary Examination Data Request (*initial data call*) was for a listing of all credit life claims which were paid during the examination period. From this listing a sample was selected and forwarded to the Company requesting copies of the sample claims files (documents). On two occasions the examiners requested specifically supporting payment information. Those requests are copied, in relevant part, below:

(April 15, 2005)

**1) Paid Credit Life Claims (Sample IX)**

*Please refer to our request for paid credit life claims dated 12/7/04 (Sample IX).*

*The sample files have been provided, however, additional information/documents are required in order to verify compliance with VT statutes and regulations. Please furnish the following for each of the sample files identified as "Sample IX":*

- *A copy of the certificate*
- *Verifying document/s that the proceeds were either credited to the insured's account or paid to the insured's estate (Emphasis added)*

(November 8, 2005)

*C. In each of these cases, there was no evidence of payment of the credit life insurance payment as requested. Each of the sample files do contain a ledger print out which appears to indicate the balance of the member's savingS account or as referenced in the ledger: "share account". Additionally, there is no*

*supporting evidence that the member's account was credited with the life savings life insurance payment (if that, as it appears, was provided). Explain why these documents are missing. (Emphasis added)*

## **See Appendix I**

### **(3) Inaccuracy of Reported Populations**

As part of the "Preliminary Examination Data Request", the examiners requested listings of paid and denied credit life claims and paid and denied credit disability claims occurring during the examination period, from which sample claim files were selected .

The examiners observed, upon completion of the review of the sample claim files, that in some instances the requested information as to the populations of these claims appeared to contain inaccuracies as described below.

The review of the denied Loan Protection claims sample, which consisted of four (4) files, revealed that these claims were not Loan Protection claims but were life savings claims. The examiners inquired as to why the listing included life savings claims. The Company responded: *The processing system used to adjudicate loan protection and life saving claims contains separate claim status fields for both products. Regardless of the specific product being adjudicated, the system allows each product field to be populated with a payment or denial code. The four life saving claims that were included in the loan protection report, contained a "denial" code populated in the loan protection status field. We are currently updating our report query to eliminate this issue.*

Subsequently, the examiners requested that the Company certify that the counts (populations) of the denied Loan Protection life claims were accurate, to which the Company responded that the total number of denied Loan Protection life claims was sixty-six (66). This was the initially reported amount, apparently not accurate information in light of the above statement. It wasn't until December 2005, over one (1) year from the date the examination began; that the Company furnished an updated Loan Protection denied claim report which contained a total of thirty-eight (38) denied Loan Protection claims.

Further discrepancies were noted with regard to denied credit life claims. The Company reported that there were four (4) denied credit life claims during the examination period. The review of these four (4) claim files revealed that that two (2) of the claims were Loan Protection life claims. The Company's explanation was that the two (2) Loan Protection claims were erroneously entered and processed as regular credit life claims. The Company advised that although the claims were entered as credit life claims, they were converted to Loan Protection claims and processed correctly.

**(D) ISSUED CERTIFICATES –POPULATIONS**

The examiners requested listings of all credit life certificates that were issued in the state of Vermont during the examination period, including those issued for the Company’s Loan Protection product, which is a non-contributory group policy. The Company was not able to produce the requested listings. The Company furnished the following explanation of how these numbers are reported on the Vermont state pages of the Annual Report:

*New certificate counts are estimates, based on the total inforce and the new certificate frequency on single premium Credit Life. Only the Single Premium Credit Life has actual certificate detail backing it up. Therefore, the value reported on the State Page for Line 21, Column 3 for the number of certificates issued in a given year is determined by applying a ratio to the total number of certificates inforce at 12/31.*

*CUNA Mutual Group only knows the number of certificates issued for Single Premium. For monthly pay certificates, we only obtain the total number of certificates inforce. A ratio is obtained as follows:*

*Total number of Single Premium certificates issued (for all states)  
----- = Ratio of issued to inforce in total Population  
The total number of Single Premium Certificates inforce at 12/31*

*This ratio is then applied to each state’s total number of certificates inforce at 12/31 to obtain the number of issued certificates during the year.*

**(E) CONCLUSION AND RECOMMENDATIONS**

The Company’s failure to produce its records for examination, as detailed in this section of the report, represents violations of Vermont’s Regulations 99-1 § 4 A. (1) and (2), 99-1 § 6, 99-1 § 7 A. (1) and § 7 B.

The Regulation requires that insurers preserve any records relating to the business of insurance, necessary for efficient and effective insurance regulation, so as to be made readily available for examination upon request by the Commissioner. The Company’s non-compliance with Regulation 99-1 created a major hindrance to the examination processes. Without accurate, sufficient and complete records the Department is precluded from determining the Company’s compliance with Vermont’s statutes and regulations.

The Company’s response to the examiners’ criticism was as follows:

*I agree with the above. Corrective action to be taken appears below:*

*During the course of this examination, there have been incidents in which some records were not properly maintained by our credit union partners and could not be produced to the examiners. Corrective action will be taken to educate our partners in an effort to ensure all required records are maintained and retained for the time period required under Regulation 99-1 so that they can be readily produced to examiners in the future.*

*Specifically, we will provide training regarding the requirements of Regulation 99-1 to credit unions in the state of Vermont who are engaged in enrolling members in CUNA Mutual's credit insurance program and we will review their efforts periodically. In addition, we will implement process improvements to enable more efficient reconstruction of policies that may be requested by examiners.*

Since records are maintained by the credit unions, the Company has no assurance of any back up in the event of computer failure or other catastrophe.

The examiners recommend that the Company develop and implement procedures that will enable full compliance with Regulation 99-1 by developing methods whereby the Company has records of all transactions within the state of Vermont and that the Company discontinues its reliance on the individual credit unions to maintain records which are subject to examination.

The Company should take steps in order to assure that accurate counts (populations) of the Company's claim records are presented with regard to examination requests.

Additionally, the examiners recommend that the Vermont Department conduct a follow up examination within an eighteen (18) month period following the close of this market conduct examination, in order to ensure that the Company's procedures and practices with Regulation 99-1 are in full compliance.

It is further recommended that the Company report actual certificate details in lieu of estimated figures in the state pages of their Annual Statement.

## (II) CLAIMS PROCEDURES AND PROCESSING

### (A) FAILURE TO PAY INTEREST ON CREDIT LIFE CLAIMS

The Company does not pay the statutorily required interest on death claims in accordance with 8 V.S.A. § 3665 (c ), nor does the Company pay the penalty rate (12%) for those claims paid beyond thirty (30) days of the receipt of proofs of loss, in violation of 8 V.S.A. § 3665 (d).

Initially, upon receipt of the examiners criticism, the Company agreed with the examiners stating:

*We agree a general interest payment was not provided on the referenced claims. Our interpretation of 8 V.S.A. § 3665 as a whole determined a general interest payment would not be due if the claim was paid within 30 day (sic) after receipt of properly executed proof of loss, 8 V.S.A. 3665 (c ) (1) (A). All of the above claims were processed for benefit payment with 30 days after receipt of proper proof of loss.*

*However, given the examiners findings, we will take action to include a general interest payment calculated from the date of death to date of payment.*

Subsequently, the Company “updated” its original response expressing disagreement with the examiners’ criticism for the reasons summarized below.

The Company contends that if interest was applied to the amount payable (the outstanding balance on the loan at the time of death) they would be paying more than the credit insurance law allows. The basis for their argument is 8 V.S.A. § 4105 (a) which provides that the amount of insurance should not exceed the amount of unpaid indebtedness. The Company’s interpretation is erroneous in that 8 V.S.A. § 4105 (a) defines the limits for the amount of insurance not the amount of a claim benefit. Claim benefits are comprised of the amount of insurance payable (indebtedness at time of death) plus any statutorily required interest, which in Vermont is 6%. The statutory interest is added to the amount of insurance, not part of the insured amount (outstanding indebtedness). In fact, the wording of the Company’s contract (certificate) states in relevant part: *Benefits are paid to your credit union to pay off or reduce your loan. If the benefits are more than the balance of your loan, the difference will be paid to you if you are living or the Beneficiary named by you, if any, or to your estate.* (Emphasis added)

Further, the Company argues that 8 V.S.A. § 4111 dictates exclusively the requirements of payments of claims under policies of credit life insurance and that 8 V.S.A. § 3665 (c ) is not applicable to credit life insurance. 8 V.S.A. § 4103 (1) defines credit life insurance as “insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.” (Emphasis added) 8 V.S.A. § 3301 (1) defines life insurance simply as insurance on human lives. Clearly, credit life insurance is insurance on the life

of a “debtor”. The fact that the amount of insurance is connected to a credit transaction is not relevant in defining whether or not credit life insurance falls under the legal definition of life insurance.

8 V.S.A. § 3665 (c ) (2) provides that: *All payment of claims under policies of life insurance shall include interest accrued from the date of death of the insured.* (Emphasis added)

Additionally, it is important to note that Section 3665 does **not** exempt credit life insurance from the requirements of the statute.

Interestingly, in presenting the reasons for disagreement with the criticism, the Company added, in pertinent part: *Although we could agree that interest should perhaps be payable if a claim remained unpaid for more than 30 days after receipt of a properly executed proof of loss in accordance with 8 V.S.A. § 3665 (c ) (1) (A) -----.* Apparently the Company’s interpretation of the application of 8 V.S.A. § 3665 accepts the particular provision to which it states is its practice (paying interest only if a claim is not paid timely) and rejects the provision to which it is non-compliant (paying 6% interest accrued from the date of death to the date of payment).

The examiners recommend that the Company go back as far as the Vermont Department deems appropriate and pay with interest those amounts due to the beneficiaries of the affected insureds. Additionally, the examiners recommend that the Company implement procedures by which full compliance with 8 V.S.A. § 3665 (c ) (2) and (d) is assured.

## **(B) PAID CREDIT LIFE CLAIMS**

The Company reported that a total of one hundred ninety-nine (199) credit life claims were paid during the examination period. This figure does not include Loan Protection claims. The examiners selected fifty (50) sample claim files from this population for the compliance review. It was subsequently observed that the Company, in responding to the request, provided an extra six (6) sample claim files, which the examiners incorporated into the review. Further, the examiners requested that the reported eight (8) single premium paid credit life claims be provided, thus bringing the total number of paid credit life claims’ sample size to sixty-four (64).

The filing of a death claim initiates with the individual credit union. The method of reporting a death claim most frequently used is by filing the claim electronically. Once the Company’s claims specialist reviews the information, a claim benefit decision is made. When benefits are payable, CUNA forwards the payment directly to the credit union. The credit union is instructed to apply the payment to the insured member’s outstanding loan balance. These processes are discussed in the Company’s booklet entitled Members Choice Payment Protection User Guide.

Additionally, it is important to note that the certificate of insurance states under the section entitled “**Benefits**” that the Company will pay the benefits (the principal balance of the loan on the date of death plus not more than two (2) months delinquent payments) to the credit union to pay off or reduce the principal balance of the loan and that if the benefits are more than the balance of the loan, the difference will be paid to the beneficiary or to the insured member’s estate. The credit unions are responsible for paying any excess to the beneficiary or to the insured debtor’s estate.

The examiners inquired as to whether the Company performed audits in order to ensure that the credit unions were paying the excess benefits to the insured member’s beneficiary or estate as required. CUNA’s response was: *The Company **did not** perform audits during the exam period. The Company does have a program for performing audits. Including in part verification that payment is made correctly in cases where benefits exceed the loan balance. Vermont credit unions are scheduled for audit in December 2005.* (Emphasis added)

The examiners requested copies of those audits, which according to the Company, were scheduled for December 2005, along with the dates and names (credit unions) of proposed reviews. The Company responded by submitting a copy of its newly implemented “**MEMBER’S CHOICE Compliance Review Report**”, copies of the Company’s review of twenty-six (26) credit unions’ self assessment responses and a listing entitled: “**Vermont Credit Union Reviews**” containing the names of the credit union policyholders in Vermont including those that failed to respond to the self assessment (Out of the thirty (30) credit unions listed, four (4) had not responded). The Company subsequently reported that: *In addition, since the last communication to you regarding the program we have received responses from three (3) additional credit unions leaving only one (1) credit union remaining.*

Further, the Company furnished the following response addressing the newly implemented credit union review program:

*Our practice will be to conduct reviews every three years in accordance with Vermont regulations. We commenced reviews in November 2005 with all of our group credit insurance policy holder credit unions in Vermont. The credit unions were instructed to complete a comprehensive **self assessment** designed to identify any areas within their credit insurance program that may need to be corrected. A copy of the self assessment is attached for your reference.* (Emphasis added)

*To date, we have received responses from 90 percent of Vermont credit unions surveyed. We have completed our review of these responses, and generated reports containing our findings for each of these credit unions. Enclosed are copies of the reports which are being sent to the credit unions today.* (Letter dated 2-15-06)

*In each instance in which an exception has been identified, we have notified the credit union of the exception and flagged the assessment for follow up corrective action. In some cases, instructions for the corrective action are provided to the credit union within*

*the company response contained in the report. In others, the company will be contacting the credit union to work with them directly to determine what corrective action is needed and to assist the credit union in implementing that action.*

*After we have verified that corrective action has been completed by the credit union, the assessment will be closed. Records of closed reviews will be maintained in our system for at least 5 years.*

*We have also developed an escalation plan to address credit unions who have failed to respond to the self assessment. We have implemented the first steps in that plan for the Vermont credit unions that have not responded. After we receive their responses and completed our reports, copies will be provided to you.*

Refer to **Section V** of this report which discusses the Company's failure to conduct periodic reviews of creditors with respect to their credit insurance business, violating Regulation 84-1 § 11.

The examiners recommend that the Department conduct a follow up review of the Company's newly implemented program in order to assure that the self assessment practice employed by the Company is effective in assuring compliance with the insurance laws of Vermont and the regulation promulgated by the Commissioner.

## **(C) DENIED DISABILITY CLAIMS**

The Company reported that a total of one hundred fifty-nine (159) credit disability claims were denied during the examination period. Sixteen (16) were reported to be single premium credit disability claims and the remaining one hundred forty-three (143), monthly term level rate disability claims.

### **(1) Single Premium Disability-Denied Claims**

The examiners reviewed all sixteen (16) of the reported denied single premium credit disability claims and observed one (1) irregularity as discussed below:

#### **Claim Number 4570818**

In reviewing the sample claim file, the examiners observed a form entitled "Direct Member Credit Disability Claim Notice". Under the section: "Credit Union Information", it is indicated that the date the notice was completed was **9-1-01** with a loss date of 7-26-01. The examiners observed that another claim notice was received around **4-4-03** for the same loss date. The claim was denied due to it being filed after one year from the time it should have been.

The examiners requested an explanation of as to why the Company failed to follow up or acknowledge receipt of the claim which appeared to have been filed (completed) on 9-1-01 and later denied based on the untimely filing. The Company responded as follows:

*The original notice of claim received for Mr. (Name) disability claim was received on 3/23/03. The claim notice was completed and sent by (Name) from (Name of Credit Union). Upon receipt of the claim notice, we sent to Mr. (Name) on 3/24/03 our Initial Claim Report form. This form has two parts: a section to be completed by the member and a section to be completed by the health care provider supporting disability. We received the completed Initial Claim Report form on 4/4/03. On 4/17/03 the claim was reviewed by the claims adjuster and determined a beginning date of disability of 7/27/01.*

*With a disability date beginning 7/27/01 and the notice of claim received 3/23/03, the claim was not considered for benefits as it was filed after the time frame specified within the Certificate of Insurance.*

*In regard to your inquiry pertaining to the 9/1/01 date listed on the Claim Notice, we phoned (Name) at the credit union for clarification. (Name) states she completed the form in March, 2003. She populated the date field on the form with the date she estimated would be the date (Name) would be eligible to receive benefits. The date did not reflect when (Name) notified her of his claim.*

*Having had the opportunity to review this claim in further detail, it is our determination that if this credit disability claim was received in our office today, we would process the claim for benefits according to the terms of the Certificate, in absence of the timely filing requirement. Therefore, we have calculated (Name) disability claim for benefits and determined a benefit payment of \$7,582.38. (Name) passed away on 9/20/03\*\*. We are in contact with a representative from the credit union in determining a beneficiary and/or next of kin of (Name) for receipt of this payment. (Emphasis added)*

*\*\* (a Loan Protection Life claim was paid by CMG on 11/3/03 providing a payment of \$5,963.08 which satisfied the balance of this loan)*

## **(2) Level Rate (Monthly) Disability-Denied Claims**

The Company reported that one hundred and forty-three (143) monthly term level rate disability claims were paid during the examination period. From this total the examiners selected a sample of fifty (50) claim files for review in order to determine compliance with Vermont's statutes and regulations.

The examiners observed the following irregularities and violations of Vermont's Regulations with respect to this compliance review:

### **Claim Number 2041070991**

Information contained in the sample claim file indicated that the claimant filed proof of loss on 8-6-01 and that the claim was denied on 9-7-01. Vermont Regulation 79-2 § 6 C requires that if additional time is needed in order to determine whether a claim will be

accepted or denied the claimant should receive such notice within fifteen (15) days of receipt of proof of loss. In this case there was no supporting evidence that the fifteen (15) day notice was sent to the claimant, in violation of Regulation 79-2 § 6 C.

The Company agreed with the examiners' finding and responded that it was the Company's current practice to provide a written "Delay of Claim" notification to the member when an investigation of a claim requires additional information.

**Claim Numbers 2041315651 (Loan # 71) and 2041315652 (Loan # 73)**

The examiners observed an irregularity with respect to the above referenced claims.

Two (2) claims (one for each loan) for the same insured debtor, each listing a disability date of 7-16-02, were filed simultaneously on 9-9-02. Both claims were denied for different reasons as discussed below.

The initial date the insured debtor signed up for credit disability coverage was 10-20-95.

The claim for loan # 71 was denied due to the claim being filed *after one (1) year from the time it should have been filed*. The Company contends that the insured debtor met the definition of disability, with respect to loan # 71 on 6-1-96 (the date the insured debtor first injured his hand) not the listed date of disability, as provided by the insured member, of 7-16-02; thus supporting the reason for denial.

The claim for loan # 73 was denied due to the pre-existing condition exclusion. In this case, the Company employed a different effective date of coverage, which was based on the date the insured initiated an advance on his loan, which was 6-27-02. (Refer to the section entitled **Company's Practice of Determining Effective Date of Coverage** following this discussion) Additionally, the Company determined that the effective date the insured debtor became disabled, with respect to loan # 73, was 7-16-02 (as the listed date of disability (as provided by the insured member) for both claims); thus supporting the reason for denial.

Information contained in the claim file indicates that a new period of disability was established for loan # 73. The examiners questioned the Company as to why this new period of disability (7-16-02) was not applied to loan # 71, in which case the claim would have been paid.

The Company responded in relevant part as follows:

*In order for loan # 71 to be eligible for future disability benefits associated with the right hand disability, the member must recover from the right hand disability for more than seven days. The Certificate of Insurance states:*

*If your Total Disability recurs within seven (7) days after you have recovered from that period of Total Disability, we will consider this a continuation of that period of Total Disability. However, if your Total Disability recurs more than seven (7) days after you have recovered, we will consider it a new period of Total Disability.*

*At no time did the member fully recover from the right hand injury of 6-1-96, thus continuing that period of disability associated with his right hand. Subsequently when the member incurred surgery 7-16-02 on his right hand, loan # 71 remained ineligible for disability benefits for the right hand disability because he at no time recovered from the original right hand disability period. (Emphasis added)*

In an earlier response to the examiners' inquiry as to the handling of this claim, the Company stated with respect to the claim for loan # 73, that:  
*When Mr. (Name) was not able to work at all due to the increased severity of his injury, a new period of disability was established for loan 73 because his condition, at the time he elected coverage on 6-27-02, had worsened. (Emphasis added)*

According to information contained in the claim file, the insured debtor did return to work after the initial hand injury (6-1-96). Additionally, the examiners observed a note in the claim file which states: *for the week of 6-27-2002 member worked 40 hours that week.* Further, the examiners point out that in the Company's certificate of insurance, under the sub-heading entitled: "Credit Insurance Application/Schedule" it is stated: *You are eligible for insurance only if you are working for wages or profit for 25 hours a week or more on the date of any advance. If you are not, that particular advance will not be insured until you return to work."*

The Company advised in a letter dated 8-22-05, that: *When Mr. (Name) received his advance on 6-27-02, he was able to complete a Subsequent Action form and add credit life coverage to his loans, effective 7-22-02.* In reviewing the form referenced above (Subsequent Action) under the sub-heading entitled **Subsequent Election for Voluntary Payment Protection**, the examiners observed the following pertinent language:

*You can now voluntarily elect to become insured with the coverage(s) checked below. In order for coverage to become effective you must meet all eligibility requirements stated in the Credit Insurance Application/Schedule. (Refer to the section of this report entitled **IV Form Filings, (B) Loanliner Subsequent Action Form**)* The insured debtor at that time signed up for both credit disability and credit life insurance for the advance on his loan.

With the insured debtor's declaration of being actively at work for 25 hours a week or more and the Company's acceptance of his request to add credit life insurance effective 7-2-02, along with the statement from his employer that he worked 40 hours the week of 6-27-02, it seems reasonable to assume that the insured debtor had sufficiently recovered from his initial disability of 6-1-96, and that when his condition worsened, prompting the

filing of the claim, a new period of disability should have been established for both claims.

The examiners recommend that the Company reconsider the payment of the disability claim for loan # 71.

**Note: Company's comments subsequent to the examination:**

The Company was afforded an opportunity in which to respond to *factual* assertions or errors contained in the draft report prior to submission to the Department. The Company continued to object to the examiners' request to reconsider the payment of the disability claim for loan # 71, asserting that (even though the insured member was eligible for credit life insurance on 7-2-02 and had returned to work) the *member did not fully recover from the right hand injury of 6-1-96*. Adding in relevant part that: *Therefore, there is no new period of disability for loan number 71*. The Company further requested that this section of the report be removed.

**(i) Violations of Regulation 79-2 (Fair Claims Practices)**

- Reference claim number 204112728102. The claim was received by the Company on 03/10/03. The acknowledgement of receipt of the claim was sent to the claimant on 04/01/03, seventeen (17) working days later. Similarly, for claim # 204105314102, the claim was received on 03/18/02 and acknowledged on 04/12/02, twenty (20) working days later. In these two cases the Company was in violation of Regulation 79-2 § 5 A, which requires an insurer to acknowledge receipt of a claim notice directly to the claimant within ten (10) working days.
- Reference claim number 204105314102. The completed initial claim report (proof of loss) was faxed to the Company on March 18, 2002. The Company denied the claim on April 12, 2002, which was nineteen (19) working days later. The Company failed to notify the claimant within fifteen (15) working days after receipt of the proofs of loss that more time was needed to determine whether the claim should be accepted or denied in violation of Regulation 79-2 § 6 C.
- Reference claim number 204121436301. The claimant sent a written inquiry regarding her outstanding claim, which was received by the Company on May 23, 2002. The Company did not respond until July 2, 2002, which was twenty-seven (27) working days later. An additional written inquiry was sent to the Company, which was received on January 9, 2003. The Company did not respond until February 3, 2003, which was sixteen (16) working days later, failing to comply with Regulation 79-2 § 5 B.

**(ii) Failure to Promptly Determine Coverage**

Reference claim number 204128738101. The claim was received by the Company on 05/25/02, which was initially denied on 06/10/02 due to the pre-existing condition

exclusion. On 06/27/02, the Company received a letter from the claimant's physician disputing the assertion in the denial letter that the condition was pre-existing. The Company notified the claimant's credit union on 07/03/02 that additional medical information was required and, on 08/09/02; the Company notified the doctor's office of the need for the additional documentation. On 09/16/02, the claimant contacted his Congressman and asked for assistance in receiving a response from the Company with regard to his disability claim. Subsequently, on 09/25/02, the credit union informed the claimant that he had not elected credit disability insurance and therefore had no coverage.

The insured debtor had to wait four (4) months before the Company informed him that he did not have coverage and that his claim would be denied. Additionally, the insured debtor found it necessary to contact his Congressman in order to receive a determination of acceptance or denial of his claim. The Company failed to verify whether or not the applicable coverage was in force as a first step in the claims process.

The Company responded to the examiners inquiry as to its procedures with regard to verification of coverage as follows: *As the Contract Policyholder, the credit union enrolls members, collects premium, maintains enrollment forms and files claims on behalf of the member certificate holders. The verification of coverage is completed by the credit union according to their records upon notice of filing a claim from their member. If questions arise during the processing of the credit insurance claim in regard to coverage status, we will request from the credit union copies of their records for review or verification.*

The section in this report entitled **Production of Records** includes a recommendation that the Company maintain records of all transactions in the state of Vermont and that reliance upon the credit unions to furnish such records be discontinued. Verification of coverage, which is usually the first step in processing claims, could then be accomplished by the Company thus avoiding delays and confusion, as discussed above.

### **(iii) Denial of a Claim Based on Incomplete Information**

Claim number 204101638901 was denied based on information furnished by a Dr. "K"; however, Dr. "K" stated that: *Perhaps Dr. "E" from (name) could give you more insight into answering the question whether a nanny was necessary and whether being out of work was necessary.* Notwithstanding Dr. "K's" suggestion, the file does not contain evidence that the Company made any attempt to seek information from Dr. "E". The Company's denial letter erroneously stated that the denial was based on information received from both Dr. "K" and Dr. "E" when, in fact, the Company had apparently failed to seek any information from Dr. "E". The Company acknowledged that the inclusion of Dr. "E's" name was an error.

The examiners recommend that, in the future, the Company obtain complete information from all doctors whom they have reason to believe might possess pertinent information before denying a claim.

#### **(D) COMPANY'S PRACTICE OF DETERMINING EFFECTIVE DATE OF COVERAGE**

During the course of the review of the denied credit disability claims sample (monthly term level rate), the examiners observed that the Company's practice of determining the effective date of coverage did not appear to be in accordance with Regulation 84-1 § 7 (2) (a).

Regulation 84-1 § 7 (2) (a) provides that a claim for disability shall not be denied due to *pre-existing conditions except for those conditions for which the insured debtor received medical advice, diagnosis, or treatment within six months preceding the effective date of the debtor's coverage and which caused loss within the six months following the effective date of coverage.* (Emphasis added)

The Company applies a new exclusionary period for each draw or advance on those open end loans which allow periodic draw downs on a credit line based on the date/s of the drawn down or advance; not the effective date of coverage, thus establishing various effective dates of coverage for the same insured loan.

The effective date of coverage as defined by 8 V.S.A. § 4106, is the date when the debtor becomes obligated to the creditor not the date of the various advances the insured debtor may effectuate. Obligation is defined in pertinent part, as an agreement or duty by which one person is legally bound to make payment or becomes obligated by contract setting forth the terms of an agreement, therefore, the date the debtor becomes obligated to the creditor is the date the original loan documents are executed and the borrower (debtor) elects credit insurance coverage and becomes indebted to the creditor.

Further, 8 V.S.A. § 4107 (c ) and (d) require that the Company deliver to the insured debtor at the time the indebtedness is incurred either a policy or group certificate of insurance or a copy of the application and that such *application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as of the date the indebtedness is incurred.* (Emphasis added) The statute does not provide for various effective dates of coverage otherwise the Company would be in violation of this statute in that it does not issue or deliver to the insured debtor at the time of the advance (indebtedness) a new certificate or notice of proposed insurance each time an advance is made on the insured loan.

Six (6) sample claim files from the sample of fifty (50) denied disability monthly term level rate claims were denied due to the pre-existing condition exclusion, subjecting the insured debtor to a new exclusionary period based upon the date/s of the advance not the initial effective date of coverage. Since all the sample claim files did not contain copies of the original application verifying the initial effective date of coverage, it is possible that additional claims were denied due the new exclusionary period.

The Company responded in disagreement stating:

*Attached is correspondence with the Vermont Department of Banking, Insurance, Securities & Health Care Administration on this issue exchanged during the form filing process. Based upon the comments we provided at that time, the forms were approved and no further inquires were made by the Department pertaining to the issue.*

*Your criticism states that “obligation is defined in pertinent part, as an agreement or duty by which one person is legally bound to make payment or becomes obligated by contract setting forth the terms of an agreement, therefore, the date the debtor becomes obligated to the creditor is the date the original loan documents are executed and the borrower (debtor) elects credit insurance coverage.”*

*8 V.S.A. § 4106 states: “The term of any credit life insurance or credit accident and health insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor....”*

*A debtor does not become legally bound to make payment on an advance or become obligated by contract setting forth the terms of an agreement for an advance until money is advanced to him or her. So the date that the debtor becomes obligated is the same as the date of the advance.*

*The Certificate of Insurance, as approved by the Department, states:*

**Total Disabilities Not Covered.** *We won't pay a claim for any advance on a loan or return your disability insurance premium if your Total Disability:*

- 1. begins within six (6) months after the Effective Date of insurance on the advance and results from any disease or bodily injury for which you received medical advice, diagnosis or treatment at any time within the six (6) month period immediately preceding the Effective Date of insurance on the advance; or*

*In summary, the effective date of coverage on an advance is the later of the date of the advance or the date coverage is elected on the advance. Each advance has its own effective date of coverage to be used in determining the application of the pre-existing condition restriction. We feel we are in compliance with Vermont statutes and regulations on this issue.*

The examiners recommend that the Department reconsider its approval of the Company's certificate of insurance which allows the Company to employ the effective date of the advance as the effective date of coverage, when determining the pre-existing condition restriction.

**See Appendix II**

## (E) LOAN PROTECTION

The Company's Loan Protection Program is designed to provide coverage for either life insurance or life insurance with total and permanent disability benefits for the credit unions' members. The product is a non-contributory group life insurance policy whereby the credit union pays the premiums from its funds, thus there is no direct charge to the insured members for this coverage.

Each credit union determines the classes of loans for which coverage will be offered. Limits as to the amounts of coverage are also elected by the credit unions. There is no member election or enrollment required, however, each insured member is provided a certificate of insurance with a qualifying loan.

Similarly, as with the monthly term level rate certificates written by the credit unions, the Company does not receive copies of the certificates or the number of certificates written by the credit unions. The only record the Company receives is a monthly report of the credit unions' insured balances under the Loan Protection Program.

As previously discussed in this report, under the section entitled **Claims Procedures and Processing (A) Failure to Pay Interest on Credit Life Claims**, the Company does not pay the statutorily required interest on credit life claims including those paid under the Loan Protection Program, which provides a benefit in the amount of the loan balance upon the death of the insured debtor as with contributory credit life insurance.

The Company agreed with the examiners' initial criticism by stating: *We agree a general interest payment was not provided on the referenced claims. Our interpretation of 8 V.S.A. § 3665 as a whole determined a general interest payment would not be due if the claim was paid within 30 day (sic) after receipt of properly executed proof of loss, 8 V.S.A. § 3665 (c ) (1) (A). All of the above claims were processed for benefit payment within 30 days after receipt of proper proof of loss.*

*However, given the examiners findings, we will take action to include a general interest payment calculated from the date of death to date of payment.*

Similarly, as with the criticism involving credit life claims, the Company "updated" its response by expressing disagreement for basically the same reasons. However, the Company extended their comments with respect to those life claims paid under the Loan Protection Program, by adding the following:

*Moreover, it is the creditor that pays the premiums for CUNA's loan protection products, not the debtor. To require payment of interest to the debtor in the circumstance where the creditor has paid all the premiums would also unjustly enrich the debtor by paying him amounts for which he is not indebted. This particular product could be viewed as*

*more in the nature of a casualty line of insurance rather than life insurance. See, e.g. 8 V.S.A. § 3301 (3) (K).*

It is important to note that credit unions are required to be operated solely for the benefit of their members. As such, all expenses of the credit unions are paid from assets of the credit unions. Such assets belong entirely to the members. The insured members, therefore, participate indirectly in the cost of the coverage. Additionally, contrary to the Company's statement quoted above, the payment of a life insurance claim has no relationship to the source of the premium. Credit life insurance is clearly not casualty insurance by definition of law. 8 V.S.A. § 4103 (1) defines credit life insurance as insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction. (Emphasis added) 8 V.S.A. § 3301 (1) defines life insurance simply as insurance on human lives. The Company's contention that these credit life policies written under the Loan Protection program *could be viewed as more in the nature of a casualty line of insurance* contravenes the legal definition of *life insurance* and more specifically *credit life insurance*.

Further, the Company stated that: *loan protection contracts are arranged and all premiums are paid for by the creditor. The benefits that are offered to the creditor through a loan protection agreement are payment of the amount outstanding on a loan. The benefits are paid to the lending credit union, not the borrower. When these features are taken as a whole, it is clear that a loan protection product is fundamentally different from a life insurance product making 8 V.S.A. § 3665 (c ) (2) wholly inapplicable.*

The Company's statement that credit life insurance and its Loan Protection product are fundamentally different is not entirely correct. The major difference is that the Company's credit life products are considered to be contributory group life insurance, elected by and paid by the individual debtor. The life insurance premium, under the Loan Protection Program, is paid by the credit union and is considered to be non-contributory group life insurance.

## **(F) LIFE SAVINGS COVERAGE**

One of the group policies CUNA offers to the credit unions is designed to insure the lives of credit union members for an amount of insurance based on their credit union savings balance. This product is entitled "Life Savings" insurance. As with the Company's companion product, "Loan Protection" coverage, the premiums for the "Life Savings" coverage are paid by the credit unions from their funds. Each member qualifies for insurance on the balance of his savings up to an amount not to exceed the "Protected Savings Balance" elected in the application without any requirement of his insurability. If an insured member dies while he is insured under this policy, the Company pays the proceeds to the credit union. A member may name the person to whom he wants the proceeds of his insurance paid, in which case the credit union is instructed to pay the named beneficiary.

To reiterate, the Company does not pay the statutorily required rate of interest on death claims pursuant to 8 V.S.A. § 3665 (c ), including claim payments with respect to this product.

It is important to point out that this coverage (Life Savings) is **not** by definition of law *credit life insurance*, but is in fact ordinary life insurance. 8 V.S.A. § 4103 (1) provides the legal definition of *credit life insurance* as follows:

*“Credit life insurance” means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction. (Emphasis added)*

### (III) RATES AND RELATED ISSUES

Credit life and credit disability insurance is provided to cover the loans made by credit unions to their members whereby each credit union is the policyholder of a group master policy under which the member debtors are issued certificates rather than individual policies. Maximum permissible rates are filed with the Vermont Department by the Company for each individual credit union under the case rating procedure set forth in Vermont Regulation 84-1 § 10 (4). It is the Company’s responsibility to see that the credit unions do not charge their member debtors any rate which exceeds the maximum rates approved by the Vermont Department. Since this is a report by exception and since each credit union has a separate and distinct schedule of rates, only those credit unions for which violations were noted by the examiners are discussed in this section of the report under separate headings identified by the credit unions contract numbers.

**Contract Number 044-0003-3**

Fifty (50) sample files were requested for the review, however, the examiners only received twenty-five (25) complete files. Refer to the section of this report entitled **Production of Records (B) (1)**.

The table below details those applications in which the insurance coverage elected was different from the coverage for which the credit union was charging the member.

**Inconsistencies between Elected Coverages and Premiums Charged**

<b>Account #</b>	<b>Coverage Elected on Application</b>	<b>Date Premium Remitted</b>	<b><u>A</u> Loan Balance</b>	<b><u>B</u> Premium Charged</b>	<b><u>B/(A/1000)</u> Rate per thousand</b>
5701-B	Single Credit Life	12/06/03	1,786.40	1.48	.83 (joint life rate)
6543-A	None	12/16/03	1,456.29	1.83	1.26 (single disb. rate)
6543-A	None	12/16/03	1,456.29	1.21	.83 (joint life rate)
10340-A	None	12/29/03	4,852.25	4.03	.83 (joint life rate)
10340-A	None	12/29/03	4,852.25	6.11	1.26 (single disb. rate)

In addition, on the application for Account# 5993-E, the boxes were checked to elect single credit disability and joint credit life, however, the rest of the application was blank and the applicant did not sign it.

The Company responded that these findings are accurate and that refunds were calculated and deposited to these members' accounts on 01/09/06 as detailed in the following chart:

### Refunds of Premium Overcharges

Account #	Date Charges Began	Date Charges Ended	Credit Disability Refund	Joint Credit Life Refund	Total Refund
6543-A	August-02	July-04	65.74	43.31	109.05
10340-A	December-03	November-05	106.25	69.99	176.24
5993-E	October-00	December-04	104.27	68.72	172.99
5701-B	December-02	October-05		20.51	20.51

Furthermore, the Company instructed the credit union to change the insurance codes on the members' accounts to properly reflect the elections made.

The examiners recommend that, in addition to these refunds that were made, the Company conduct a periodic review of this credit union to assure compliance with Vermont insurance laws and regulations, as required by Regulation 84-1 § 11 and addressed in the section of this report entitled: **(V) Supervision of Credit Insurance Operations.**

The Company provided a rate chart which contained the types of credit insurance issued during the examination period and the corresponding rates listed by credit union. The rate chart indicated that credit union # 044-0003-3 issued 30-day non-retro level rate credit disability until 04/30/03. A new rate of \$.97 per thousand was approved for this coverage in the rate filing approved on 10/04/02. The Company stated that this rate filing was implemented on 04/01/03, however, the Company failed to lower the rate upon its implementation and continued to charge \$1.26 per thousand until it discontinued issuing the coverage on 04/30/03. Therefore, any members who had 30-day non-retro level rate credit disability insurance from 04/01/03 until 04/30/03 were charged the \$1.26 rate instead of \$.97 per thousand in violation of 8 V.S.A. § 4109 (a).

The Company responded to the criticism: *We will calculate and provide a refund to (credit union # 044-0003-03). We will encourage the credit union to reimburse affected borrowers to the extent their records are still available to identify the insured borrowers during April 2003. Since credit unions are financial cooperatives, any remaining funds will be used to the benefit of the membership as a whole.*

The examiners recommend that the Company and the credit union collaborate in order to audit and refund the members who were overcharged and that the refunds be made under the auspices of the Vermont Department. The fact that the overcharged premiums would result in remaining funds that benefit the membership as a whole would not make it equitable for the individual members who were overcharged.

**Contract Number 044-0016-9**

The rate chart, provided by the Company, indicated that credit union # 044-0016-9 charged \$1.16 per thousand for 30-day non-retro level rate credit disability from 08/01/93 through 03/31/03. The Company filed a rate filing containing a requested rate of \$1.05 per thousand for this coverage which was approved by the Vermont Department on 11/03/99. The Company stated that this rate filing was implemented on 04/01/00, however, they failed to lower the rate from \$1.16 to \$1.05 per thousand upon its implementation in violation of 8 V.S.A. § 4109 (a).

The examiners reviewed the rates of a sample of fifty (50) files, from credit union # 044-0016-9, with respect to 30-day non-retro level rate credit disability coverage. The review resulted in a total of thirty-seven (37) instances where the Company charged a rate of \$1.16 per thousand when the maximum rate approved by the Department was \$1.05 per thousand. The members who were found during the review to have been overcharged are listed in the table below:

**Members Charged a Rate of \$1.16 instead of the Approved Rate of \$1.05 (per thousand)**

Member Number
1339500
1511300
1367000
1517800
1584000
1784500
1964600
2046400
2202100
2531000
2550800
2739400
2775000
3061600
3068700
3156900
3486900

3490400
3547900
3584600
3615600
3797600
3835200
3965000
4661300
5004100
5053800
5083900
401100
408600
391000
5567600
5217500
5629800
5898600
5972400
6039600

The Company responded to the criticism: *We will calculate and provide a refund to (credit union # 044-0016-9). We will encourage the credit union to reimburse affected borrowers to the extent their records are still available to identify the insured borrowers during the time period.* In addition, the Company commented: *Since credit unions are financial cooperatives, any remaining funds will be used to the benefit of the membership as a whole.*

The examiners recommend that the Company and the credit union collaborate in order to audit and refund the members who were overcharged and that the refunds be made under the auspices of the Vermont Department. The fact that the overcharged premiums would result in remaining funds that benefit the membership as a whole would not make it equitable for the individual members who were overcharged.

**Contract Number 044-0078-7**

Vermont Regulation 84-1 (Appendix I, (B)) states that *prima facie maximum premium rates for terms of coverage not specified in Appendix I shall be actuarially consistent with this table of rates.* The examiners observed that credit union # 044-0078-7 did not interpolate the rates for its single premium credit disability certificates with terms between those for which prima facie maximum rates are given in Appendix I of Vermont Regulation 84-1. Instead, the Company used the rates for the next higher terms in Appendix I. This was the Company’s procedure with all of its credit unions that issued

single premium credit disability for terms between those for which rates are given in Appendix I. The following certificates issued by credit union # 044-0078-7 were noted as examples of this practice:

**Single Premium Credit Disability Certificates  
for Which Rates Were Not Interpolated**

Certificate Number	Actual Term	Used Rate For
DF 275671	40 Mos.	48 Mos.
DV 066276	25 Mos.	36 Mos.

The Company responded that: *the single premium rate schedule approved by the state in November 1989 does not interpolate for months between 12, 24, 36, 48, and 60. The rates shown at these yearly points are used for each of the months prior to the stated month in the regulation going back as far as the previous yearly rate from the regulation. This means the approved prima facie rate at 25 months is the same as the rate at 36 months; and the rate at 40 months is the same as the rate at 48 months.*

Although the Company’s rate table was approved by the Department, the examiners question whether it is equitable, for example, to charge the same rate for 25 months of credit disability as for 36 months of coverage. It is suggested that the Department may wish to reconsider its approval of these rates in view of the requirement of Vermont Regulation 84-1 (Appendix I, (B)) that the rates for terms of coverage not specified in Appendix I be actuarially consistent with those contained in the regulation.

**Contract Number 044-0060-6**

Credit union # 044-0060-6 began issuing 14-day non-retro level rate credit disability on 06/01/00. The Company considered it a “plan change” from 30-day non-retro, which was issued prior to that date. The case rate for this credit union’s (# 044-0060-6) 14-day non-retro level rate credit disability, which was filed in the rate filing approved on 10/04/02, was based on experience from 1999, 2000, and 2001. Experience from the 30-day non-retro plan was included from 1999 to the effective date of 06/01/00 for calculating the case rate for the 14-day non-retro plan.

The Company stated that it considered the two plans to meet the definition of a multiple account case as defined in Regulation 84-1 § 10 (6) (b) (ii) and applied in Regulation 84-1 § 10 (4) (a) (i). The Company further stated that their understanding of the standard case rate procedure was *for multiple account cases a single case rate is calculated for all of the data comprising the multiple account case and it is applicable to each of the plans (single accounts) making up the multiple account case.*

The Company added: *The Company reviewed the last several rate filings it made and has not found a place where it explicitly requested approval to consider all plans of one creditor a multiple account case. Our filing memoranda have consistently indicated that we would treat accounts with 50% credibility as cases for case rating purposes. The word “account” in our usage means credit union. In Vermont, in those instances where there are multiple plans, the plans occur in succession as opposed to concurrently. Our business is mostly monthly premium, so active certificates change plan when the credit union does so.*

*The logic for combining successive plans for purposes of calculating the prima facie loss ratio is that the membership is the same and the group of borrowers is largely the same in the months before and after the plan change. Exclusion of the experience data would likely result in the new plan alone becoming pool rated rather than case rated. The resulting pool rating would likely be replaced later by a return to case rating. This can lead to artificial rate volatility because the case rated account makeup can differ markedly from the pool makeup.*

The examiners responded that Regulation 84-1 § 10 (6) (b) (ii) defines a multiple account case as two or more accounts of the same insurer having similar underwriting characteristics that are combined by the insurer for premium rating purposes with the approval of the Commissioner.

The Company could not provide documentation of the Commissioner’s approval of the combining of the experience for 14-day non-retro and 30-day non-retro disability to make a multiple account case rate. The Company responded: *We have not found where CUNA Mutual explicitly requested that two plans of one credit union be allowed in a single case. However, since the multiple account case approval relates to accounts with similar underwriting characteristics, CUNA Mutual thought approval of a multiple accounts covering a single group of people would be reasonable.*

By mixing experience for 14 day non-retro and 30 day non-retro disability in determining the deviated rate for 14 day non-retro issued by this credit union the Company was in violation of Regulation 84-1 § 10 (3) (c) which specifies how deviated rates may be determined. Without approval by the Commissioner of a multiple account case, the Company should have filed the rates separately for each plan of insurance without mixing the experience in determining the rates. The Company should obtain approval from the Commissioner of any multiple account cases in the future.

## (IV) FORM FILINGS

### (A) CERTIFICATES OF INSURANCE

The Company's Certificates of Insurance (form numbers B3d-820-0786 VT and B3d-821-0786 VT) used for single premium and monthly premium products do not conform to the requirements of 8 V.S.A. § 4107 (b). The statute provides that each individual policy or group certificate of credit life insurance or credit accident and health insurance shall, among other requirements of law, set forth: *the name or names of the debtor, the premium or amount of payment, if any, by the debtor separately for credit life insurance and credit accident and health insurance, a description of the coverage including the amount and term thereof.* (Emphasis added)

The Company's Certificates of Insurance do not provide the required contents as described above and underlined for emphasis, representing violations of 8 V.S.A. § 4107 (b) and Vermont Regulation 84-1 § 3 (3) (b).

The Company responded in disagreement with the criticism, stating:

*We have reviewed the filings for certificate forms that CUNA Mutual has submitted to the Vermont Insurance Department over the past 20 years. Section 4107(b) has never been included among the objections received from the VT Insurance Department. Several iterations of our certificate forms that have not included the name(s) of the debtor or the amount of premium have been approved by the Department.*

*The name(s) of the debtor and the premium are, however, included in the Member's Application for Credit Insurance. The Member's Application accompanies and becomes a part of the Certificate. In most cases the Member's Application and the Certificate are printed as attached documents. In instances where the two forms are not printed as attached documents, our credit union training program instructs the credit union to present both forms together to the insured member.*

The examiners recommend that the Company develop certificates of insurance that fully comply with the specific requirements of 8 V.S.A. § 4107 (b) and seek approval from the Vermont Department for the use of such forms. The Company should also discontinue the use of the non-compliant certificates.

## **(B) LOANLINER SUBSEQUENT ACTION FORM**

The examiners criticized the Company for its failure to file and seek approval from the Vermont Department of the above referenced form in violation of 8 V.S.A. § 4108 (a), which states: *All forms of policies or contracts, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders shall be filed with the commissioner for approval prior to issuance or use by the insurer*

The Company contends that this form does not require filing and approval from the Vermont Department as it does not fall within the definition of those items described by the statute, i.e., policies or contracts, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders.

Contrarily, this form does in fact, for all intents and purposes, represent an enrollment for credit insurance. In the form entitled “Loanliner Subsequent Action”, under the section, “Subsequent Election for Voluntary Payment Protection”, the debtor is provided the option of obtaining insurance by selecting the type of coverage desired. Further, the following statement appears: *By signing below, you authorize us to add the charges for the insurance to your outstanding balance each month. Coverage election applies to the entire balance on this subaccount/ loan-----or open end plan. Insurance rates are subject to change.* Clearly, the language contained in the form suggests that it is an enrollment/application for insurance and as such must be filed with the Vermont Department in accordance with 8 V.S.A. § 4108 (a).

The Company responded to the criticism by stating that necessary action to discontinue the use of the subsequent election contained in the Loanliner Subsequent Action form would be initiated.

## **(C) APPLICATION FORMS**

The examiners observed that the application forms for credit insurance used by the various credit unions were materially different from the forms approved by the Department. Specifically, the application forms approved by the Department were on 8.5 x 11 inch pieces of paper with the name of the insurance Company and the city and state of the home office prominently displayed as a centered heading at the top. The versions of the applications used by the Company were on legal size paper embedded into the loan agreement and truth-in-lending disclosure statement, with the credit insurance application comprising about one-third of the page. In some cases, the Company’s name did not appear anywhere on the application form.

A specific example is application form # APP.820-0786, approved by the Department on 11/06/89, which is materially different from the two versions of APP.820-0786 used by the Company. The two versions used by the Company were on forms with the headings “Loan and Security Agreements and Disclosure Statement” and “Consumer Credit Disclosure Form, Promissory Note and Security Agreement”. The version entitled “Consumer Credit Disclosure Form, Promissory Note and Security Agreement” did not

contain the name of the insurance company or the city and state of the home office. The version entitled “Loan and Security Agreements and Disclosure Statement” contained the name of the insurance company and the city and state of the home office, however, it was not a prominently displayed centered heading as in the approved version.

The “Loan and Security Agreements and Disclosure Statement” did not contain the title “Your Application for Credit Insurance” as did the approved application. Neither form contained the prominently displayed heading “Member’s Application for Credit Life and/or Disability Insurance Credit Insurance Schedule” as was contained in the approved application. Furthermore, the layout of the form and size of the print used was vastly different from the approved application and the approved application was not imbedded in a promissory note, security agreement or truth-in-lending disclosure form.

The credit life and credit disability applications used by the Company are not the same as the approved application forms. Therefore, the Company used application forms that were not approved by the Department, in violation of 8 V.S.A. § 4108 (a).

The Company responded: *We agree that on some of the documents that the department reviewed that some language was missing and that the name and address of the company was not centered. We will correct that for all new applications given to credit unions.*

*When the application was presented for approval in 1989 we believed that the approval was for the language of the form and not specifically the format. Our customers require the application/enrollment to be incorporated into several different types of documents as well as document types, such as paper copies in various sizes and electronically produced documents in various formats and by various tools. There is no “one size fits all” method of producing these documents 16 years after the language was approved.*

*One of the reasons that CUNA Mutual has incorporated the enrollment and certificate into the lending forms is to make sure that the borrower actually receives those documents as required by 8 V.S.A. Section 4107 (c). The documents that you reviewed were multi-part documents with the parts specifically to be given to the borrower designated as the “Borrower Copy”. Since CMG has the responsibility to make sure that credit unions are giving the correct documents to the borrower we have found that one of the most fail safe ways of doing this is by having all the documents used in the lending transaction be part of one package. Then the credit union loan officer does not have to locate additional forms for the credit insurance. It also is helpful to the consumer in that the loan documents and insurance applications are on the same document for purposes of easy reference when determining whether a particular loan had coverage.*

The examiners recommend that the Company either use the application forms approved on 11/06/89 or obtain the Department’s approval of the forms that are currently being used.

## **(D) LOAN PROTECTION CERTIFICATE OF INSURANCE FORM APPROVALS**

The Company provided the examiners with two form filings pertaining to Loan Protection coverage, one dated October 11, 1983 and the other dated February 8, 1985. These filings contained provisions to be included in the certificates of insurance instead of filing individual certificates for each credit union.

The following policy provision is contained in the Loan Protection Certificate of Insurance for Vermont VAF Employees, Vermont State Employees, Chittenden County Teachers, Bennington County Teachers, Bryant, PMH, Heritage Family and Border Lodge Credit Unions:

*You are not insured for any class of loans which has been excluded from coverage or which is not being reported for coverage by the Credit Union. Please see the Credit Union and the Group Policy for details on which loans are not covered.*

This clause did not appear in the filings provided for the Loan Protection Program.

The following provision, included in the Loan Protection Certificate of Insurance for Vermont VAF Employees, Chittenden County Teachers, PMH, Heritage Family, and Border Lodge Credit Unions, contains additional language (emphasized by underlining), which was not in the approved provision:

*If you Become Totally and Permanently Disabled prior to your 60<sup>th</sup> birthday and while you are insured under the Group Policy, we will pay off the insured balance of your loan on the same basis as if we were paying a death claim, unless otherwise specified. By Total and Permanent Disability, we mean that because of a medically determined illness or injury you will never again be able to work at your own job or at any other paying job for which you are suited by education, training or experience for the rest of your life. We won't pay a disability benefit unless you have accepted all reasonable medical or surgical treatment to remove your disability. If we pay a disability benefit, you will no longer qualify for insurance under the Group Policy.*

Regulation 84-1 § 4 (2) requires that certificates of insurance delivered or issued for delivery in Vermont be filed with the Commissioner. The two provisions detailed above were not filed with the Commissioner and therefore constitute violations of Regulation 84-1 § 4 (2).

The Company agreed that this language had not been approved by the Vermont Department and indicated that they would discontinue the use of the unapproved language in the certificates.

## (V) SUPERVISION OF CREDIT INSURANCE OPERATIONS

Vermont Regulation 84-1 § 11 requires that:

*(1) Each insurer transacting credit insurance in this state shall be responsible to conduct a thorough periodic review of creditors with respect to their credit insurance business with such creditors to assure compliance with the insurance laws of this state and the regulation promulgated by the Commissioner.*

*(2) Written records of such reviews shall be maintained by the insurer for review by the Insurance Commissioner and retained for a period of at least 5 years.*

The examiners found that the Company failed to perform any periodic reviews of its Vermont creditors as required by the regulation notwithstanding the fact that, in a letter dated October 4, 2004, they furnished an exhibit entitled “Premium Review Process” indicating that premium reviews are conducted and that upon completion of the reviews, the findings are summarized and communicated to the credit unions with details of the findings. The examiners requested copies of all such reviews completed during the examination period. The Company responded that: *We have not performed any premium reviews on credit unions in the state of Vermont during the examination period.*

When these violations of Vermont Regulation 84-1 § 11 were brought to the Company’s attention they responded on July 27, 2005 as follows:

*We will conduct a full review of all Vermont credit unions with respect to their credit insurance business to assure compliance with the insurance laws of Vermont. We will complete the review within one year from this date and will maintain written records of the reviews for at least 5 years.*

Refer to section: **(II) CLAIMS PROCEDURES AND PROCESSING (B)**, for a detailed discussion regarding the corrective action the Company implemented December 2005, subsequent to the examination period.

The examiners recommend that the Department conduct a follow up review of the Company’s newly implemented program (as discussed in the above referenced section of this report) in order to assure that the self assessment practice employed by the Company is effective in assuring compliance with the insurance laws of Vermont and the regulation promulgated by the Commissioner.

## (VI) PRODUCER LICENSING

The Company's products are marketed through its group policyholders (credit unions) to their members. The contract (group policy) between the Company and the credit unions stipulates policy parameters such as, terms and definitions, exclusions and restrictions, duties of the insured credit union etc. The "General Provision" section of the policy/contract, under the subsection entitled "Administrative Expense Of The Policyholder" provides: *We may agree to reimburse you for your administrative expense in connection with your performance of the prescribed duties as the policyholder.*

According to the Company, these reimbursements are unique for each credit union and are individually negotiated. Each credit union is required to report monthly the total number of insured loans (dollar amount) and the dollar amount of the collected premiums. The reimbursement amount is based on a negotiated percentage of the premium.

Further, the packet that accompanies the policy/contract contains an "Instruction Page" which provides a listing of documents, one of which is entitled: "Instructions and Product Info Sheet" containing the following language: *This sheet can be used for training staff on your insurance products or for selling the insurance product(s) to your members.* (Emphasis added)

Clearly, the prescribed duties of the credit unions (policyholders) include marketing (selling) the insurance product(s) to their members.

8 V.S.A. § 4796 (Commissions, payment; acceptance) provides:

*(a) An insurance company, insurance producer, limited lines or surplus lines broker shall not pay a commission, service fee, brokerage or other valuable consideration to a person for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this chapter and is not so licensed.*

"Person" is defined under 8 V.S.A. § 4813a. as follows: *"Person" means an individual or a business entity.*

8 V.S.A. § 4813b. provides that: *A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance unless the person is licensed for that line of authority in accordance with this subchapter.* (Emphasis added)

The Company is in violation of 8 V.S.A. § 4793 (a) and § 4813b in that the personnel of the credit unions who market (sell) the insurance products to their members are not licensed in accordance with Vermont's licensing statutes. Moreover, the Company is in violation of 8 V.S.A. § 4813l. in that CUNA failed to appoint its producers or file such notice of appointment with the Commissioner or pay the required \$60.00 appointment fee for each insurance producer.

The Company responded in relevant part to the criticism as follows:

*CUNA Mutual agrees that it has not required the credit union credit personnel who were involved in the enrollment of debtors in credit insurance plans to hold producer licenses. Further, it agrees that it has not appointed credit union credit personnel who were involved in the enrollment of debtors in credit insurance plans to act as its agents in Vermont. Under the circumstances described below, however, such failure was reasonable and was the result of recent changes in Vermont law whose effect of producer licensing for credit insurance provided in connection with loans by credit unions were neither apparent nor communicated to the affected class of putative licensees.*

The Company provided a written proposal for correction of its activities to the Department on August 10, 2005, stating in pertinent part: *CUNA Mutual's August 10 proposal is based on the provisions of Vermont law contained in 8 V.S.A. § 4813d and 4813f, discussions with the Department concerning entity and limited lines licenses for credit unions and their loan personnel and guided by the rental car rule cited above. Until a final rule for credit insurance producers is effective or other formal written guidance is provided by the Department, CUNA Mutual requests the Department approve its August 10 corrective action plan. (Emphasis added)*

Note: The “rental car rule” referenced in the above statement, according the Company, is: *Regulation I-2002-02. Under that rule the rental car company and one natural person must be licensed as producers with responsibility to supervise the activities of non-licensed employees and representatives who enroll customers during the rental transaction.*

The examiners recommend that all persons engaged in the solicitation (selling) of insurance through the Company become duly licensed in accordance with 8 V.S.A. § 4813b and appointed as required by 8 V.S.A. § 4813l.

## **(VII) REPORTS OF LEGAL ACTIONS INVOLVING OTHER INSURANCE DEPARTMENTS**

Vermont Department Bulletin 30 requires insurance companies to report, on an annual basis, actions by the insurance department of any other state against the insurance company or by the insurance company against the insurance department of any other state, which involves any allegation of violation of law or regulation as described in the Bulletin.

The examiners noted that the Company failed to file a notice for the year 2001 with the Vermont Department as required by the Bulletin. The Company responded that there were no such actions to report for 2001 but acknowledged that the Bulletin requires affirmative notification to the Department even if no reportable action occurred in a given year and committed to filing the required notices going forward even when no reportable actions occur.

The Company's failure to file a Notice of Legal Action form for the year 2001 constitutes a violation of Bulletin 30.

## (VIII) COMPLAINTS

The Company reported having received five (5) consumer complaints during the period from January 1, 2001 through September 30, 2004 as follows:

<b>Company ID Numbers</b>	<b>Line of Insurance</b>	<b>Reason</b>	<b>Date Received</b>	<b>Date Closed</b>	<b>Insurance Dept. Complaint</b>
20010206	Credit disability	Denial of claim	4-20-01	4-25-01	Yes
20010601	Credit disability	Denial of claim	9-18-01	9-25-01	Yes
20010776	Credit disability	Denial of claim	12-03-01	12-17-01	Yes
20020428	Credit disability	Denial of claim	6-20-01	6-27-02	Yes
20041508	Credit life	Denial of claim	4-13-04	6-14-04	Yes

Four (4) of the five (5) complaints involved denied disability claims. Two (2) of the denials of disability claims were due to pre-existing conditions and pertained to the same individual except on two (2) different loans. One (1) denied disability claim resulted from the claimant filing their claim one (1) year after the deadline permitted by the policy and another was denied because the benefit reached the maximum amount of insurance covered by the policy. The examiners did not find any irregularities regarding the denial of the credit disability claims.

The credit life claim was denied, according to the complainant, because the policy was not in force for six (6) months prior to filing a claim on the death of her husband. The claimant stated that she could not find a provision with this limitation. The Company subsequently paid the claim.

## SUMMARY OF RECOMMENDATIONS

**1.**

**Page 19**

The examiners recommend that the Company develop and implement procedures that will enable full compliance with Regulation 99-1 by developing methods whereby the Company has records of all transactions within the state of Vermont and that the Company discontinues its reliance on the individual credit unions to maintain records which are subject to examination.

**2.**

**Page 19**

The Company should take steps in order to assure that accurate counts (populations) of the Company's claim records are presented with regard to examination requests.

**3.**

**Page 19**

The examiners recommend that the Vermont Department conduct a follow up examination within an eighteen (18) month period following the close of this market conduct examination, in order to ensure that the Company's procedures and practices are in full compliance with Regulation 99-1.

**4.**

**Page 19**

It is recommended that the Company report actual certificate details in lieu of estimated figures in the state pages of their Annual Statement.

**5.**

**Page 21**

The examiners recommend that the Company go back as far as the Vermont Department deems appropriate and pay with interest those amounts due to the beneficiaries of the affected insureds. Additionally, the examiners recommend that the Company implement procedures by which full compliance with 8 V.S.A. § 3665 (c ) (2) and (d) is assured.

**6.**

**Page 27**

It is recommended that the Company reconsider payment of the claim identified by claim numbers 2041315651 (Loan # 71) and 2041315652 (Loan # 73).

**7.**

**Page 28**

The examiners recommend that, in the future, the Company obtain complete information from all doctors whom they have reason to believe might possess pertinent information before denying a claim.

**8.**

**Page 30**

The examiners recommend that the Department reconsider its approval of the Company's certificate of insurance which allows the Company to employ the effective date of the advance as the effective date of coverage, when determining the pre-existing condition restriction.

**9.**

**Pages 36 & 37**

The examiners recommend that the Company and the credit unions (contract numbers 044-0003-3 and 044-0016-9) collaborate in order to audit and refund the members who were overcharged and that the refunds be made under the auspices of the Vermont Department.

**10.**

**Page 38**

It is suggested that the Department may wish to reconsider its approval of the uninterpolated credit disability rates for the reasons discussed in this report.

**11.**

**Page 39**

The Company should obtain approval from the Commissioner of any multiple account cases in the future.

**12.**

**Page 40**

The examiners recommend that the Company develop certificates of insurance that fully comply with the specific requirements of 8 V.S.A. §4107 (b) and seek approval from the Vermont Department for the use of such forms. The Company should also discontinue the use of the non-compliant certificates.

**13.**

**Page 42**

The examiners recommend that the Company either use the application forms approved on 11/06/89 or obtain the Department's approval of the forms that are currently being used.

**14.**

**Pages 44 (& 23)**

The examiners recommend that the Department conduct a follow up review of the Company's newly implemented program (as discussed in sections **II (B) and V**) with respect to its non-compliance with Regulation 84-1 § 11, in order to assure that the self assessment practice employed by the Company is effective in assuring compliance with the insurance laws of Vermont and the regulation promulgated by the Commissioner.

**15.**

**Page 46**

The examiners recommend that all persons engaged in the solicitation (selling) of insurance through the Company become duly licensed in accordance with 8 V.S.A. § 4813b and appointed as required by 8 V.S.A. § 4813l.

## APPENDIX I

**Claim files that did not contain evidence of payment of claim proceeds as requested:**

**Claim Numbers:**

4645696  
4228201  
4228202  
4228211  
4307846  
4256441  
4645942  
4478004  
4228714  
4543370

## APPENDIX II

### Denied Credit Disability Claims (Due to pre-existing conditions based on effective date of advance)

<b>Claim Number</b>	<b>Initial Date Insured</b>	<b>Date/s of Advance</b>
4617757	12-3-96	6-5-03
4553444	10-20-95	6-27-02
4573288	12-12-88	11-7-02, 11-22-02, 12-10-02, 1-27-03 and 2-28-03
4575621	4-25-02	2-20-03
4635372	11-9-96	7-8-03 & 7-22-03
4469067	5-11-01	4-4-02, 5-7-02, 5-14-02, 5-30-02, 6-2-02 6-30-02